STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005109	A. BUILDING _____ B. WING _____	07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL SOUTH	1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of 1 (one) State hospital complaint. Complaint: #IN00101946 Unsubstantiated; lack of sufficient evidence. Facility: #005109 Date: 7/23/2012 & 7/24/2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Community Hospital South is in compliance with 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules. QA: claughlin 08/03/12	S 000		